		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035485

Facility Name: Swann Special Care Center

Address: 109 Kenwood Road (Number) Champaign (City) 61821 (Zip Code)

County: Champaign

Telephone Number: (217) 356-5164 **Fax #** (217) 356-7873

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) James R. Johnson

(Title) V.P. of Finance - Jefferson Medical Rehab. Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)

(Print Name and Title) Robert A. Thomas

(Firm Name & Address) Katz, Sapper & Miller, LLP
11711 N. Meridian Street, Suite 800, Carmel, IN 46032

(Telephone) (317) 580-8301 Fax # (317) 580-8310

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	104	Skilled Pediatric (SNF/PED)	104	38,064	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	35,983	734	0	36,717	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,983	734		36,717	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.46%

D. How many bed-hold days during this year were paid by Public Aid?
303 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	173,016	15,275	9,265	197,556		197,556	(87,843)	109,713			1
2	Food Purchase		244,973		244,973		244,973		244,973			2
3	Housekeeping	762	21,116	104,512	126,390		126,390		126,390			3
4	Laundry	26,575	17,914	82,479	126,968		126,968		126,968			4
5	Heat and Other Utilities			74,677	74,677		74,677		74,677			5
6	Maintenance	52,634	16,709	41,421	110,764	825	111,589		111,589			6
7	Other (specify):*											7
8	**TOTAL General Services**	252,987	315,987	312,354	881,328	825	882,153	(87,843)	794,310			8
	B. Health Care and Programs											
9	Medical Director			31,200	31,200		31,200		31,200			9
10	Nursing and Medical Records	2,329,896	191,431	8,226	2,529,553	(41,668)	2,487,885		2,487,885			10
10a	Therapy	11,380	3,531	114,675	129,586		129,586		129,586			10a
11	Activities	81,159	6,143	981	88,283		88,283		88,283			11
12	Social Services	3,264	239	139	3,642		3,642		3,642			12
13	Nurse Aide Training					41,668	41,668		41,668			13
14	Program Transportation		8,390	1,628	10,018		10,018		10,018			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,425,699	209,734	156,849	2,792,282		2,792,282		2,792,282			16
	C. General Administration											
17	Administrative	65,558		90,710	156,268	(90,158)	66,110	(552)	65,558			17
18	Directors Fees					8,187	8,187		8,187			18
19	Professional Services			476,052	476,052	26,527	502,579		502,579			19
20	Dues, Fees, Subscriptions & Promotions			7,884	7,884	227	8,111	(2,078)	6,033			20
21	Clerical & General Office Expenses	59,918	22,119	28,596	110,633	30,117	140,750	(7,178)	133,572			21
22	Employee Benefits & Payroll Taxes			622,911	622,911	5,309	628,220		628,220			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,070	14,070	1,310	15,380		15,380			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,921	18,921		18,921		18,921			26
27	Other (specify):* Bad Debts			21,612	21,612		21,612	(21,612)				27
28	**TOTAL General Administration**	125,476	22,119	1,280,756	1,428,351	(18,481)	1,409,870	(31,420)	1,378,450			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,804,162	547,840	1,749,959	5,101,961	(17,656)	5,084,305	(119,263)	4,965,042			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Swann Special Care Center #0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			133,840	133,840	107	133,947		133,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			424,910	424,910	17,325	442,235	154,010	596,245			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,003	1,003		1,003		1,003			34
35	Rent-Equipment & Vehicles			10,887	10,887	(622)	10,265		10,265			35
36	Other (specify):* **Amortization**			38,383	38,383		38,383	175,407	213,790			36
37	**TOTAL Ownership**			609,023	609,023	16,810	625,833	329,417	955,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,365	2,365		2,365		2,365			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			303,308	303,308		303,308		303,308			42
43	Other (specify):* **Educ/Day Training**	957,959	42,737	164,520	1,165,216	846	1,166,062		1,166,062			43
44	**TOTAL Special Cost Centers**	957,959	42,737	470,193	1,470,889	846	1,471,735		1,471,735			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,762,121	590,577	2,829,175	7,181,873		7,181,873	210,154	7,392,027			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(36,967)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,500)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,612)	27		24
25	Fund Raising, Advertising and Promotional	(1,875)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(678)	21		28
29	Other-Attach Schedule See Attached	278,338			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 210,706		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(552)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (552)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 210,154		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Swann Special Care Center

ID# 0035485

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	School Lunch Reimbursement	$ (87,843)	1	1
2	Goodwill Amortization	(27,835)	36	2
3	Miscellaneous Income	(203)	20	3
4	Loss on Early Extinguishment of Debt	190,977	32	4
5	Loss on Early Extinguishment of Debt	203,242	36	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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75				75
76				76
77				77
78				78
79				79
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	278,338		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(87,843)	0	0	0	0	0	0	0	0	0	0	(87,843)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(87,843)	0	0	0	0	0	0	0	0	0	0	(87,843)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(552)	0	0	0	0	0	0	0	0	0	(552)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,078)	0	0	0	0	0	0	0	0	0	0	(2,078)	20
21	Clerical & General Office Expenses	(7,178)	0	0	0	0	0	0	0	0	0	0	(7,178)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(21,612)	0	0	0	0	0	0	0	0	0	0	(21,612)	27
28	**TOTAL General Administration**	(30,868)	(552)	0	0	0	0	0	0	0	0	0	(31,420)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(118,711)	(552)	0	0	0	0	0	0	0	0	0	(119,263)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	154,010	0	0	0	0	0	0	0	0	0	0	154,010	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	175,407	0	0	0	0	0	0	0	0	0	0	175,407	36
37	**TOTAL Ownership**	329,417	0	0	0	0	0	0	0	0	0	0	329,417	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	210,706	(552)	0	0	0	0	0	0	0	0	0	210,154	45

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Exceptional Care & Training Center	Sterling			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Beam Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Health Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	$ 90,710	Hoosier Care, Inc.	100.00%	$ 90,158	$ (552)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 90,710			$ 90,158	$ * (552)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	9,339			Director Fees	$ 2,030	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	9,339			Director Fees	2,030	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	9,339			Director Fees	2,030	18.8	3
4	John Foos	Director	Board Meetings	0.00	4,821			Director Fees	1,048	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	4,818			Director Fees	1,049	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,187		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, Kentucky 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Director's Fees	Revenue	36,997,938	8	$ 45,843	$ 0	6,607,267	$ 8,187	1
2	19	Professional Services	Revenue	36,997,938	8	148,540	0	6,607,267	26,527	2
3	20	Fees, Subscription & Promotion	Revenue	36,997,938	8	997	0	6,607,267	178	3
4	21	Clerical & General Office Exp.	Revenue	36,997,938	8	167,599	0	6,607,267	29,931	4
5	22	Emp. Benefits & Payroll Tax	Revenue	36,997,938	8	28,380	0	6,607,267	5,068	5
6	24	Travel & Seminar	Revenue	36,997,938	8	15,875	0	6,607,267	2,835	6
7	30	Depreciation	Revenue	36,997,938	8	597	0	6,607,267	107	7
8	32	Interest Expense	Revenue	36,997,938	8	97,010	0	6,607,267	17,325	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 504,841	$		$ 90,158	25

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Champaign Bonds - 1989A		X	Purchase of Facility	Varies	08/01/89	$ 5,830,000	$	08/01/19	9.7500	$	1
2	Ill. Health Financing Authority		X	Purchase of Facility	Varies	07/08/99	5,710,000	5,675,000	06/01/34	7.1250	398,185	2
3	Ill. Health Financing Authority		X	Purchase of Facility	Varies	07/08/99	260,000	255,000	06/01/19	10.5000	26,725	3
4												4
5												5
	Working Capital											
6	Home Office Allocation										17,325	6
7												7
8												8
9	TOTAL Facility Related						$ 11,800,000	$ 5,930,000			$ 442,235	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,800,000	$ 5,930,000			$ 442,235	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Swann Special Care Center **#** 0035485 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	33,035	8
	1996		9
	1997		10
	1998		11
	1999		12

Note: The facility became tax exempt from property taxes starting on 01/01/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,257 B. General Construction Type: Exterior Block & Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED Facility	89,603	1989	$ 538,000	1
2					2
3	TOTALS	89,603		$ 538,000	3

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1989	1975	$ 2,592,000	$ 59,116	10-40	$ 59,116	$	$ 955,335	4
5	9			1993	319,955	10,665	30	10,665		97,194	5
6	8			1996	N/A	N/A	N/A	N/A		N/A	6
7											7
8											8
	Improvement Type**										
9	Paint & Panels			1989	1,308		3			1,308	9
10	Blinds			1990	384		3			384	10
11	Fire Doors			1990	2,751	275	10	275		2,751	11
12	Storm Windows			1991	4,224	423	10	423		3,839	12
13	Fire Doors			1991	3,675	368	10	368		3,340	13
14	Compressor			1991	1,035	104	10	104		933	14
15	Carpeting			1991	220	22	10	22		196	15
16	Sprinkler & Fire Alarm			1991	695	70	10	70		616	16
17	Sprinkler			1992	3,162	316	10	316		2,687	17
18	Damper			1992	674	67	10	67		566	18
19	Fire Alarm System			1992	1,945	195	10	195		1,639	19
20	Water Heater			1992	1,998	97	7	97		1,998	20
21	Roofing			1992	3,900	390	10	390		2,958	21
22	Voltage Relay			1993	1,875	188	10	188		1,408	22
23	Sprinkler System			1993	14,460	1,446	10	1,446		10,604	23
24	Wall Covering			1993	3,190	319	10	319		2,286	24
25	Wall Papering			1993	3,000	300	10	300		2,125	25
26	Blinds with Valance			1993	2,395	240	10	240		1,679	26
27	Carpet and Rubber Base			1993	2,848	285	10	285		1,994	27
28	Replace Siding			1993	575	57	10	57		396	28
29	Remodeling in Team Rooms			1993	9,405	941	10	941		6,351	29
30	Plexiglas for Doors & Walls			1993	714	71	10	71		480	30
31	Resurface Parking Lot			1993	19,115	1,911	10	1,911		12,741	31
32	Shed			1993	5,990	599	10	599		4,143	32
33	Stain New Shed			1993	1,248	125	10	125		854	33
34	Fire Doors, Closets, Tile			1993	5,225	522	10	522		3,481	34
35	Architectural Renovation			1993	855	85	10	85		561	35
36	TOTAL (lines 4 thru 35)				$ 3,008,821	$ 79,197		$ 79,197	$	$ 1,124,847	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install Alarm & Nurse Call			1994	688	69	10	69		436	9
10	Heat Pump			1994	2,017	202	10	202		1,245	10
11	Paving for New Sign			1994	680	68	10	68		414	11
12	Labor for Laying Brick - Sign			1994	1,000	100	10	100		608	12
13	Sign for Dedication			1994	325	32	10	32		196	13
14	Sign and Granite Pieces			1994	1,300	130	10	130		791	14
15	Material for Leasehold Improvements			1995	7,858		3			7,858	15
16	Hoods, Fans, Ansul System			1995	2,500	250	10	250		1,333	16
17	Work for Exhaust Fan & Hood			1995	3,995	399	10	399		2,095	17
18	Day Room Addition			1995	3,337	334	10	334		1,698	18
19	Replace Water Heater			1995	3,750	375	10	375		1,906	19
20	Day Room Additional Supplies			1995	1,926	193	10	193		981	20
21	Walk-in-Cooler			1995	3,334	333	10	333		1,582	21
22	Nurse Call System			1996	1,198	120	10	120		520	22
23	Shed			1996	2,034	203	10	203		863	23
24	Air Conditioner Compressor			1996	1,208	121	10	121		494	24
25	Supplies for Leasehold Improvements			1996	3,091		3			3,091	25
26	Building Addition - Materials & Labor - 1,500 Square Feet Multi-Purpose										26
27	Activity Room & Bathroom Addition plus renovation										27
28	to the Dental Office			1996	180,928	9,046	20	9,046		38,446	28
29	Construct Screens, Wheelchairs			1996	1,420	198	3	198		1,420	29
30	Construct Shelving, Beds, Screen			1996	2,964	412	3	412		2,964	30
31	Install Nurse Call System			1996	1,530	153	10	153		612	31
32	Tile Flooring & Adhesive			1996	1,227	123	10	123		471	32
33	Linoleum Flooring			1996	686	69	10	69		253	33
34	Install New Drain Pipes			1996	2,190	219	10	219		803	34
35	Remove Concrete to Replace Drain Pipes			1996	575	58	10	58		212	35
36	TOTAL (lines 4 thru 35)				$ 231,761	$ 13,207		$ 13,207	$	$ 71,292	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install Exit Door Hardware			1997	874	87	10	87		297	9
10	Day Training Improvement			1997	4,078	1,020	4	1,020		2,546	10
11	Install New Disposal			1997	1,069	107	10	107		294	11
12	Replace Four-Door Glass			1998	520	52	10	52		121	12
13	Remove / Replace Underground Fuel Tank			1998	9,223	461	20	461		768	13
14	Remodel Project 2410 Springfield			1998	33,764	8,441	4	8,441		13,365	14
15	Partition Wall Kitchen / Dinning Area			1998	595	74	8	74		117	15
16	Replace Two Roof-Top HVAC Units-Wings I&II			1998	17,650	1,765	10	1,765		2,795	16
17	Replace Vent Damper Assembly - Hot Water Heater			1998	740	74	10	74		117	17
18	Convert Two Classrooms into Resident Rooms			1998	15,258	1,526	10	1,526		2,416	18
19	Security Door and Hardware - Converted Rooms			1999	520	52	10	52		74	19
20	Remove / Replace Hot Water Heater - Resident Area			1999	3,000	300	10	300		350	20
21	Replace Combustion Motor/Fan on Heater - West Wing			1999	1,155	116	10	116		145	21
22	Electrical Service Move Switches			1999	141	18	8	18		25	22
23	Installation of Water Heaters			1999	595	60	10	60		70	23
24	Resurface Parking Lot			1999	2,350	144	15	144		144	24
25	14 Almond FRP Panel Dividers			1999	513	94	5	94		94	25
26	Install Alarm System			2000	2,000	33	5	33		33	26
27	Install Alarm System			2000	2,730	46	5	46		46	27
28	Replaced Compressor on Freezer			1999	635	53	10	53		53	28
29	Replace Grout, Base, and Tile for Bathroom Floors			1999	594	33	15	33		33	29
30	Replaced Bracket / Filter Head, Brushes, Relay on Generator			1999	2,782	209	10	209		209	30
31	Storage Barn			1999	120	4	25	4		4	31
32	Storage Barn			1999	1,045	31	25	31		31	32
33	Replaced Wall Heat Pump Unit			1999	1,525	114	10	114		114	33
34	New Mixing / Tempering Valve for Hot Water			2000	629	31	10	31		31	34
35	Replace Timer / Starter on Emergency Generator			2000	2,153	108	10	108		108	35
36	TOTAL (lines 4 thru 35)				$ 106,258	$ 15,053		$ 15,053	$	$ 24,400	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install Interior Retrofit Energy Efficient Lighting			2000	15,090	252	20	252		252	9
10	Rounding					(6)		(6)		(8)	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 15,090	$ 246		$ 246	$	$ 244	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 117,288	$ 18,225	$ 18,225	$		$ 67,797	37
38	Current Year Purchases	12,561	997	997			997	38
39	Fully Depreciated Assets	405,573	1,880	1,880			405,573	39
40	Home Office Allocation	(1)	107	107				40
41	TOTALS	$ 535,421	$ 21,209	$ 21,209	$		$ 474,367	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	1985 GMC Bus	1993	$ 16,250	$ 500	$ 500	$	4	$ 16,167	42
43	Patient Transportation	1985 GMC Bus	N/A	4,041	1,347	1,347		3	3,031	43
44	Patient Transportation	1989 Ford Mini Bus	1998	3,000	600	600		5	1,050	44
45	See Attached			13,440	2,588	2,588		4-5	3,780	45
46	TOTALS			$ 36,731	$ 5,035	$ 5,035	$		$ 24,028	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,472,082	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 133,947	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 133,947	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,719,178	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	New Patient Rooms	$ 111,760	58
59			59
60			60
61		$ 111,760	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage Bld.				1,003			5
6								6
7	TOTAL				$ 1,003 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 7,617 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	1994 Ford E350sup	$ 529.54	$ 2,648	17
18					18
19					19
20					20
21	TOTAL		$ 529.54	$ 2,648	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 130

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		21,373		21,373
4	Clinical Wages	(b)		9,953		9,953
5	In-House Trainer Wages	(c)		10,342		10,342
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 41,668	$	$ 41,668
10	SUM OF line 9, col. 1 and 2	(e)	$ 41,668			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	39
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	39

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,402	$	1
2	Cash-Patient Deposits	72,413		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 23,100)	1,084,077		3
4	Supply Inventory (priced at Cost)	38,273		4
5	Short-Term Investments			5
6	Prepaid Insurance	(14,150)		6
7	Other Prepaid Expenses	607		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Corporate	(4,509,608)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (3,315,986)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	3,361,929		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	572,153		16
17	Accumulated Depreciation (book methods)	(1,719,178)		17
18	Deferred Charges	358,620		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,943		21
22	Other Long-Term Assets (specify):	712,389		22
23	Other(specify): Goodwill	809,546		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,636,402	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,320,416	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,220	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	72,413		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,051		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	35,927		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 341,052	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,930,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,930,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,271,052	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,950,636)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,320,416	$	48

***(See instructions.)**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,018,779)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,018,779)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(931,859)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	2	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (931,857)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,950,636)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,303,974	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,303,974	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	8,430	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,430	8
	C. Other Operating Revenue		
9	Payments for Education	501,787	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	40,493	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 542,280	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,967	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,967	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	270,317	28
28a	Miscellaneous Income (See Attached)	88,046	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 358,363	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,250,014	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	881,328	31
32	Health Care	2,792,282	32
33	General Administration	1,428,351	33
	B. Capital Expense		
34	Ownership	609,023	34
	C. Ancillary Expense		
35	Special Cost Centers	1,167,581	35
36	Provider Participation Fee	303,308	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,181,873	40
41	**Income before Income Taxes (line 30 minus line 40)****	(931,859)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (931,859)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,015	2,015	$ 44,508	$ 22.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	45,382	48,461	844,657	17.43	3
4	Licensed Practical Nurses	541	564	8,232	14.60	4
5	Nurse Aides & Orderlies	132,901	142,675	1,432,499	10.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	450	668	11,380	17.04	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,091	2,091	25,858	12.37	9
10	Activity Assistants	6,457	6,800	55,301	8.13	10
11	Social Service Workers	72	72	3,264	45.33	11
12	Dietician					12
13	Food Service Supervisor	2,092	2,137	31,733	14.85	13
14	Head Cook	7,302	7,806	83,288	10.67	14
15	Cook Helpers/Assistants	2,093	2,618	24,980	9.54	15
16	Dishwashers	3,055	3,213	33,015	10.28	16
17	Maintenance Workers	3,776	4,030	52,634	13.06	17
18	Housekeepers	99	99	762	7.70	18
19	Laundry	1,981	2,211	26,575	12.02	19
20	Administrator	2,000	2,080	65,558	31.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,733	5,189	59,918	11.55	24
25	Vocational Instruction					25
26	Academic Instruction	33,961	36,231	436,508	12.05	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,452	3,464	51,949	15.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	41,111	43,769	469,502	10.73	33
34	TOTAL (lines 1 - 33)	295,564	316,193	$ 3,762,121 *	$ 11.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	304	$ 9,265	1.3	35
36	Medical Director	416	31,200	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	160	750	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1,013	65,853	10a.3	41
42	Respiratory Therapy Consultant	255	7,660	10a.3	42
43	Speech Therapy Consultant	764	41,163	10a.3	43
44	Activity Consultant	22	981	11.3	44
45	Social Service Consultant				45
46	Other(specify) Dental Fees	N/A	4,290	10.3	46
47	Utilization Review	40	1,496	10.3	47
48	See Attached	21,465	245,553		48
49	TOTAL (lines 35 - 48)	24,439	$ 408,211		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Max Redmond	Administrator	0	$ 65,558
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,558

B. Administrative - Other

Description	Amount
Corporate Expenses	$ 90,710
TOTAL (agree to Schedule V, line 17, col. 3)	$ 90,710
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jefferson Medical Rehabilitation		$
Centers, Inc.	Management Fees	397,440
Katz, Sapper & Miller, LLP	Accounting Fees	2,778
Holleb & Coff	Legal Fees	5,932
Dobbins, Fraker, Tennant	Legal Fees	3,095
Erwin, Martinkus, Cole & Ansel	Legal Fees	34,964
Handy Law Office	Legal Fees	5,884
Hensley Law Office	Legal Fees	837
Duane, Morris & Heckahe	Legal Fees	24,662
Miscellaneous Fees	Legal Fees	460
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 476,052

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,998
Unemployment Compensation Insurance	5,439
FICA Taxes	280,299
Employee Health Insurance	222,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	30,003
Corporate Allocation	5,068
TOTAL (agree to Schedule V, line 22, col.8)	$ 628,220

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 97)	975
Illinois Health Care Assoc.	4,074
MES of Illinois	55
Corporate Allocation	178
Chamber of Commerce	195
Other Fees (see attached)	2,031
Less: Public Relations Expense	(1,680)
Non-allowable advertising	(195)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,033

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,514
Seminar Expense	6,031
Corporate Allocation	2,835
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,380

**See instructions.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,411** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **303,308**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **87,843**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **27,570**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PriceWaterhouseCoopers** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.